Region 10

# SUBSTANCE USE DISORDER
# FINANCIAL INFORMATION AND PAYMENT AGREEMENT

The SUD Program Provider is a non-profit organization financed by consumer payments, funds from federal, state and local government and contributions. If you have insurance benefits, these sources must be billed in order to pay for part of the cost of the services you receive.

**COMPLETION OF THIS FORM IS VOLUNTARY;** however, if you choose to withhold the information requested, you will be responsible for paying the standard charge(s) for the service(s) you receive. The outpatient rate schedule is posted.

**Program Name**: _____

| | | |
|---|---|---|
| Consumer's Name | Case # | DOB: |
| Guarantor's (Responsible Party) Name: | Soc Security # | Relationship to Consumer: |
| Address: | DOB: | Telephone/Home: |
| City/State/Zip: | | |
| Guarantor's Employer: | | Telephone/Work: |
| Address: | | |
| Name and age of dependents per Michigan Income Tax Return: | | |

**INSURANCE INFORMATION**

We cannot bill your insurance company unless you provide Region 10 with your insurance information. (**Please attach a copy of your insurance card(s) front and back to this agreement)**. All insurance benefits must be identified and used prior to using Medicaid benefits, as payer of last resort.

| | | | |
|---|---|---|---|
| Primary Insurance: | | Policy/Contract Number: | |
| Name & DOB of Subscriber: | | Group Number: | |
| | | | |
| Secondary Insurance: | | Policy/Contract Number: | |
| Name & DOB of Subscriber: | | Group Number: | |
| | | | |
| Tertiary Insurance: | | Policy/Contract Number: | |
| Name & DOB of Subscriber: | | Group Number: | |

## II.

☐ I certify that the above information is accurate, and I agree to notify Region 10 of any changes in this information during the course of my treatment.

☐ I authorize payment directly to Region 10 for any insurance benefits to which I am entitled and authorize the release of information needed to process insurance claims.

☐ I agree to endorse over to Region 10, within 10 business days, any insurance reimbursement checks that may be sent directly to me (subscriber). Failure to do so may result in me being charged the full cost of service and my account may be turned over to collections.

Copies of all insurance cards have been obtained and are attached: Yes ☐ No ☐

If not Medicaid eligible, proof of application and/or denial dated within the past 30 days has been provided:
Yes ☐ No ☐ Comments: _____

***Consumers with current Medicaid, ABW, Healthy Michigan Plan or MI Child benefits will be assessed no fee for Substance Use Disorder services (Not to include Medicaid Spend Down, State Medical Program or Children's Special Health Care Services).***

**Omit this box if consumer has already provided the necessary documents and proceed to section III.*

**I do not have the needed document(s) to accurately assess my fee today. Failure to return the necessary documents needed to complete the fee assessment will result in monthly fee equal to full cost of all services provided. I will provide information within 14 days from the date signed below:**

_____ _____
Signature Date

## III.

**Income (Michigan State Income Tax Return):**

Copy of Michigan State Income Tax Return, W-2 or check stub(s), as well as unemployment income verification when applicable has been provided and is attached: Yes ☐ No ☐

If no, reason: _____

_____

A) Consumer $_____ Year: _____
B) Spouse $ _____ Year: _____
C) Guarantor/Responsible Party $ _____ Year: _____

**Your assessed Ability to Pay for Substance Use Disorder services based upon your Michigan taxable income per the sliding fee scale (See page 4) is $_____ per month, effective_____.**

**IV.**

**Check as item is explained:**

☐ Payment is expected at the time of service. Failure to pay fees within 60 days from the date of service may result in the use of a collection agency/credit bureau or even result in the termination of services.

☐ A $20.00 processing fee will be charged for a non-sufficient funds check returned by the bank.

☐ If a Consumer/Responsible Party willfully fails to provide relevant insurance coverage information to the Substance Use Disorder services program or if a responsible party willfully fails to apply to have insurance benefits that cover the cost of services provided to the individual paid to Region 10, the responsible party's ability to pay shall be determined to include the amount of insurance benefits that would be available. If the amount of insurance benefits is not known, the responsible party's ability to pay shall be determined to be the full cost of services.

☐ An initial bill must be presented within 2 years from the date of service or the consumer/responsible party's financial obligation is waived. Statement balances owed may be provided monthly from Region 10.

**My signature indicates that I have read and accept the assessed fee as noted on this binding agreement:**

| | |
|---|---|
| *Consumer/Guarantor (Responsible Party's) Signature | Date |
| Spouse's Signature (not required if spouse has no taxable income) | Date |
| Preparer's Signature | Date |
| Supervisor's Signature | Date |

If you are not in agreement with the above assessed fee, you may request a "New Determination" (Full Financial Review). To do so, please notify your fee assessor that you would like request a New Determination and complete the "New Determination Request" form. Upon completing the new Determination Request form, you will be asked to submit proof of your assets and expenses within 30 days. If you fail to provide the necessary information within 30 days, you will be financially responsible for the above assessed fee.

My Signature below indicates that I am requesting a new determination of my assessed fee. I understand that my failure to provide the information necessary to complete the full financial review within 30 days will result in my financial responsibility of the above fee.

| | |
|---|---|
| Consumer/Guarantor (responsible Party's) Signature | Date |

# Substance Use Disorder

Exhibit B

## FEE SCHEDULE

### EFFECTIVE MARCH 1, 2020

| Service Fee | | Min. Contribution | | 20% of Cost | | 30% of Cost | | 40% of Cost | | 50% of Cost | | 60% of Cost | | 70% of Cost | | 80% of Cost | | 100% of Cost* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Poverty Level | → | 100% | | 125% | | 150% | | 175% | | 200% | | 225% | | 250% | | 275% | | 300% | |
| One | Year/ | 0 | 12,760.00 | 12,760.01 | 15,950.00 | 15,950.01 | 19,140.00 | 19,140.01 | 22,330.00 | 22,330.01 | 25,520.00 | 25,520.01 | 27,315.00 | 27,315.01 | 31,900.00 | 31,900.01 | 33,385.00 | 33,385.01 | 38,280.00 |
| Person | Month/ | 0 | 1,063.00 | 1,063.01 | 1,329.00 | 1,329.01 | 1,595.00 | 1,595.01 | 1,861.00 | 1,861.01 | 2,127.00 | 2,127.01 | 2,392.00 | 2,392.01 | 2,658.00 | 2,658.01 | 2,923.00 | 2,923.01 | 3,190.00 |
| | Week/ | 0 | 265.75 | 265.76 | 332.25 | 332.26 | 398.75 | 398.76 | 465.25 | 465.26 | 531.75 | 531.76 | 598.00 | 598.01 | 664.50 | 664.51 | 730.75 | 730.76 | 797.50 |
| Two | Year/ | 0 | 17,240.00 | 17,240.01 | 21,550.00 | 21,550.01 | 25,860.00 | 25,860.01 | 30,170.00 | 30,170.01 | 34,480.00 | 34,480.01 | 38,790.00 | 38,790.01 | 43,100.00 | 43,100.01 | 47,410.00 | 47,410.01 | 51,720.00 |
| Persons | Month/ | 0 | 1,437.00 | 1,437.01 | 1,796.00 | 1,796.01 | 2,155.00 | 2,155.01 | 2,514.00 | 2,514.01 | 2,873.00 | 2,873.01 | 3,233.00 | 3,233.01 | 3,592.00 | 3,592.01 | 3,952.00 | 3,952.01 | 4,310.00 |
| | Week/ | 0 | 359.25 | 359.26 | 449.00 | 449.01 | 538.75 | 538.76 | 628.50 | 628.51 | 718.25 | 718.26 | 808.25 | 808.26 | 898.00 | 898.01 | 988.00 | 988.01 | 1,077.50 |
| Three | Year/ | 0 | 21,720.00 | 21,720.01 | 27,150.00 | 27,150.01 | 32,580.00 | 32,580.01 | 38,010.00 | 38,010.01 | 43,440.00 | 43,440.01 | 48,870.00 | 48,870.01 | 54,300.00 | 54,300.01 | 59,730.00 | 59,730.01 | 65,160.00 |
| Persons | Month/ | 0 | 1,810.00 | 1,810.01 | 2,263.00 | 2,263.01 | 2,715.00 | 2,715.01 | 3,168.00 | 3,168.01 | 3,620.00 | 3,620.01 | 4,072.00 | 4,072.01 | 4,525.00 | 4,525.01 | 4,948.00 | 4,948.01 | 5,430.00 |
| | Week/ | 0 | 452.50 | 452.51 | 565.75 | 565.76 | 678.75 | 678.76 | 792.00 | 792.01 | 905.00 | 905.01 | 1,018.25 | 1,018.26 | 1,131.25 | 1,131.26 | 1,237.00 | 1,237.01 | 1,357.50 |
| Four | Year/ | 0 | 26,200.00 | 26,200.01 | 32,750.00 | 32,750.01 | 39,300.00 | 39,300.01 | 45,850.00 | 45,850.01 | 52,400.00 | 52,400.01 | 58,950.00 | 58,950.01 | 65,500.00 | 65,500.01 | 72,050.00 | 72,050.01 | 78,600.00 |
| Persons | Month/ | 0 | 2,183.00 | 2,183.01 | 2,729.00 | 2,729.01 | 3,275.00 | 3,275.01 | 3,821.00 | 3,821.01 | 4,367.00 | 4,367.01 | 4,912.00 | 4,912.01 | 5,458.00 | 5,458.01 | 6,003.00 | 6,003.01 | 6,550.00 |
| | Week/ | 0 | 545.75 | 545.76 | 682.25 | 682.26 | 818.75 | 818.76 | 955.25 | 955.26 | 1,091.75 | 1,091.76 | 1,228.00 | 1,228.01 | 1,364.50 | 1,364.51 | 1,500.75 | 1,500.76 | 1,637.50 |
| Five | Year/ | 0 | 30,680.00 | 30,680.01 | 38,350.00 | 38,350.01 | 46,020.00 | 46,020.01 | 53,690.00 | 53,690.01 | 61,360.00 | 61,360.01 | 69,030.00 | 69,030.01 | 76,700.00 | 76,700.01 | 84,370.00 | 84,370.01 | 92,040.00 |
| Persons | Month/ | 0 | 2,557.00 | 2,557.01 | 3,196.00 | 3,196.01 | 3,835.00 | 3,835.01 | 4,474.00 | 4,474.01 | 5,113.00 | 5,113.01 | 5,753.00 | 5,753.01 | 6,392.00 | 6,392.01 | 7,032.00 | 7,032.01 | 7,670.00 |
| | Week/ | 0 | 639.25 | 639.26 | 799.00 | 799.01 | 958.75 | 958.76 | 1,118.50 | 1,118.51 | 1,278.25 | 1,278.26 | 1,438.25 | 1,438.26 | 1,598.00 | 1,598.01 | 1,758.00 | 1,758.01 | 1,917.50 |
| Six | Year/ | 0 | 35,160.00 | 35,160.01 | 43,950.00 | 43,950.01 | 52,740.00 | 52,740.01 | 61,530.00 | 61,530.01 | 70,320.00 | 70,320.01 | 79,110.00 | 79,110.01 | 87,900.00 | 87,900.01 | 96,690.00 | 96,690.01 | 105,480.00 |
| Persons | Month/ | 0 | 2,930.00 | 2,930.01 | 3,663.00 | 3,663.01 | 4,395.00 | 4,395.01 | 5,128.00 | 5,128.01 | 5,860.00 | 5,860.01 | 6,593.00 | 6,593.01 | 7,325.00 | 7,325.01 | 8,058.00 | 8,058.01 | 8,790.00 |
| | Week/ | | 732.50 | 732.51 | 915.75 | 915.76 | 1,098.75 | 1,098.76 | 1,282.00 | 1,282.01 | 1,465.00 | 1,465.01 | 1,648.25 | 1,648.26 | 1,831.25 | 1,831.26 | 2,014.50 | 2,014.51 | 2,197.50 |
| Seven | Year/ | 0 | 39,640.00 | 39,640.01 | 49,550.00 | 49,550.01 | 59,460.00 | 59,460.01 | 69,370.00 | 69,370.01 | 79,280.00 | 79,280.01 | 89,190.00 | 89,190.01 | 99,100.00 | 99,100.01 | 109,010.00 | 109,010.01 | 118,920.00 |
| Persons | Month/ | 0 | 3,303.00 | 3,303.01 | 4,128.00 | 4,128.01 | 4,955.00 | 4,955.01 | 5,781.00 | 5,781.01 | 6,607.00 | 6,607.01 | 7,432.00 | 7,432.01 | 8,258.00 | 8,258.01 | 9,083.00 | 9,083.01 | 9,910.00 |
| | Week/ | 0 | 825.75 | 825.76 | 1,032.25 | 1,032.26 | 1,238.75 | 1,238.76 | 1,445.25 | 1,445.26 | 1,651.75 | 1,651.76 | 1,858.00 | 1,858.01 | 2,064.50 | 2,064.51 | 2,270.75 | 2,270.76 | 2,477.50 |
| Eight | Year/ | 0 | 44,120.00 | 44,120.01 | 55,150.00 | 55,150.01 | 66,180.00 | 66,180.01 | 77,210.00 | 77,210.01 | 88,240.00 | 88,240.01 | 99,270.00 | 99,270.01 | 110,300.00 | 110,300.01 | 121,330.00 | 121,330.01 | 132,360.00 |
| Persons | Month/ | 0 | 3,677.00 | 3,677.01 | 4,596.00 | 4,596.01 | 5,515.00 | 5,515.01 | 6,434.00 | 6,434.01 | 7,353.00 | 7,353.01 | 8,273.00 | 8,273.01 | 9,192.00 | 9,192.01 | 10,112.00 | 10,112.01 | 11,030.00 |
| | Week/ | 0 | 919.25 | 919.26 | 1,149.00 | 1,149.01 | 1,378.75 | 1,378.76 | 1,609.00 | 1,609.01 | 1,838.25 | 1,838.26 | 2,068.25 | 2,068.26 | 2,298.00 | 2,298.01 | 2,528.00 | 2,528.01 | 2,757.50 |
| Amount Per | Year/ | | 4,480.00 | | 5,600.00 | | 6,720.00 | | 7,840.00 | | 8,960.00 | | 10,080.00 | | 11,200.00 | | 12,320.00 | | 13,440.00 |
| Additional | Month/ | | 373.33 | | 466.67 | | 560.00 | | 653.33 | | 746.67 | | 900.00 | | 933.33 | | 1,025.00 | | 1,120.00 |
| Family Member | Week/ | | 93.33 | | 116.66 | | 140.00 | | 163.33 | | 186.66 | | 225.00 | | 233.33 | | 256.25 | | 280.00 |
| SUD Self Pay Based on Fixed Amount | | | | | | | | | | | | | | | | | | | |
| If Income falls Within ranges Above the Sud Self Pay per Srvc will Be: | | | | $5 | | $10 | | $15 | | $20 | | $25 | | $30 | | $35 | | Full Cost | |

* Persons earning in excess of 300% of the poverty level shall be assessed a fee of full cost of services received